Inpatient Admissions and Potentially Preventable Readmissions are Trending Down

- Among all non-Dual CCNC enrollees, the Risk Adjusted Index for Inpatient Admissions and Potentially Preventable Readmissions (PPRs) continues to trend down, indicating better than expected performance. The Risk Adjusted Index is a measure of whether utilization is higher or lower than what would be expected given the population's illness burden.

- Unadjusted rates of Inpatient Admissions and PPRs are also trending down. For the CCNC enrolled Aged/Blind/Disabled (ABD) population, rates are down about 3% between Calendar Year (CY) 2011 and CY 2012.

- Among Non-ABD CCNC Enrollees, the unadjusted inpatient admission rate decreased by about 15% between State Fiscal Year (SFY) 2009 and CY 2012. For PPRs there is a more recent downward trend, where the rate decreased by 10% between CY 2011 and CY 2012.

Increase in Influenza Related Emergency Department Visits in Late 2012

- The overall rate of Emergency Department (ED) visits increased significantly in late 2012, driven by a spike in visits related to Influenza. In November and December 2012, nearly 5% of all ED visits had a Primary Diagnosis related to Influenza. In prior months, less than 0.25% of ED visits were associated with this Diagnosis.

- We compared monthly rates of CCNC enrolled ED visits to Influenza data gathered by the Centers for Disease Control and Prevention (CDC). As shown in the two figures on the next page, increases in monthly rates of CCNC enrolled ED visits (Figure 2) correspond to increases in Influenza related ED visits as identified by CDC (Figure 1). Over the past several years, December 2012 has the highest rate of Influenza related ED visits.
Analysis of CCNC Key Performance Indicators
July 2013

PMPM Costs Decrease for ABD Population, Illness Burden Likely Under-Stated

- Among ABD CCNC enrollees PMPM costs decreased by about $15 per member per month (PMPM) between CY 2011 and CY 2012.

- The Case Mix Index (CMI) is a claims-based measure of how sick a population is, or their illness burden. This measure allows CCNC to calculate expected costs, and compare these expected costs to what was actually spent for an enrolled population. In general, a higher CMI is associated with a sicker population, a lower CMI associated with a healthier population.

- After increasing between SFY 2009 and CY 2011, the CMI decreased for the CCNC enrolled population between CY 2011 and CY 2012, particularly among ABD enrollees where the CMI decreased by about 3%.

- Because CMI decreased more than actual PMPM costs, risk-adjusted PMPM performance appears to be getting worse. As shown in the graph on the next page, the Risk Adjusted Index trended up between CY 2011 and 2012, while actual PMPM costs went down.
• We identified two primary drivers contributing to the decrease in our measure of illness burden:

1) We observed a reduced prevalence of behavioral health related diagnoses in paid claims data. While some of this is attributed to data limitations related to the expansion of Local Management Entities – Managed Care Organizations (LME-MCOs), we also see the same pattern among CCNC enrollees NOT impacted by the LME-MCO expansion. For example, in a population of CCNC enrolled ABD clients living in counties not included in the LME-MCO expansion, we found the prevalence of diagnoses for Bi-Polar Disorder decreased by nearly 7% between CY 2011 and CY 2012.

2) Several new behavioral health drugs were introduced to the market in early 2012. CCNC’s risk adjustment software did not account for these new drugs, so the claims were not used when assigning illness burden. CCNC plans to update their risk adjustment software so that new drugs will be accounted for in the KPI release planned for next quarter.
Background Information
Key Performance Indicators include data from paid Medicaid claims for CCNC enrolled Non Dual Medicaid clients. When available, we also incorporate utilization data from encounter claims provided by the LME-MCOs; cost data from encounter claims are not incorporated into the KPIs.

Costs and utilization are separated out based on whether they were paid for (or historically would have been paid for) by the LME-MCOs because they are now considered capitated services. For example, LME-MCOs are now responsible for reimbursing Emergency Department (ED) visits with a primary behavioral health diagnosis. These capitated services are included in the total count/rate of ED visits, but excluded from the count of “Non-Capitated” ED visits.

Only Non-Capitated costs and utilization rates are risk adjusted. This allows us to track performance over-time, even though complete encounter data from the LME-MCOs may not be available at this time.

Results are reported for the 12 month baseline period of State Fiscal Year 2009, as well as for State Fiscal Years 2010 - 2012 (State Fiscal Years run from July through June). In addition, results are available for the most currently available 12-month period (including a roughly 6-month lag for claims and risk adjustment processing) and the two prior 12 month periods.